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**OCCUPATIONAL HEALTH SERVICES**

**OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE**

**T**he following information must be provided by every workforce member who has been selected to use any type of respirator. The Occupational Health Services will treat all information you provide in a confidential manner. (***Please Print***).

**PART A: SECTION 1**.

1. **Today's Date**: \_\_\_ /\_\_\_\_ /\_\_\_\_\_\_\_   
  
2. **Your Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
3. **Your Age (to nearest year**): \_\_\_\_\_   
  
4. **Sex**:  **Male** Female   
  
5. **Your Height**: \_\_\_\_\_\_\_ ft. \_\_\_\_\_\_\_ in.   
  
6. **Your Weight**: \_\_\_\_\_\_\_\_ lbs.   
  
7. **Your Job Title**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Supervisor’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
8. **Department**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Extension/Beeper**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
9. **A phone number where you can be reached by the health care provider who reviews this**

**questionnaire**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Best time to reach you at this number? \_\_\_\_\_\_\_\_\_\_*  
  
10. **Check the type of respirator you will use**: (*You can check more than one category if*

*applicable*):

Disposable Respirator N95

PAPR (Powered-Air Purifying Respirator)

11. **Have you ever worn a respirator**?  Yes No

**If so, what types(s):**

N95

Half or Full-Face Respirator

PAPR (Powered-Air Purifying Respirator)

SCBA (Self-Contained Breathing Apparatus)

12. **Are you allergic to latex?**  Yes No

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**PART A. SECTION 2**. Questions 1 - 9 must be answered by every workforce member who has been selected to use any type of respirator (***Please place a check mark in the “YES” or “NO”******column***.)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **QUESTION** | **YES** | **NO** |
| **1.** | Do you **currently** smoke tobacco, or have you smoked tobacco in the last month? |  |  |
|  |  |  |  |
| **2.** | Have you **ever had** any of the following conditions? |  |  |
|  | a. Seizures (fits) |  |  |
|  | b. Diabetes (blood sugar disease) |  |  |
|  | c. Allergic reactions that interfere with your breathing |  |  |
|  | d. Claustrophobia (fear of closed-in places) |  |  |
|  | e. Trouble smelling odors |  |  |
|  |  |  |  |
| **3.** | Have you **ever had** any of the following pulmonary or lung problems? | **YES** | **NO** |
|  | a. Asbestosis |  |  |
|  | b. Asthma (**If so, please complete asthma history below**)     1. In the last month, have you had asthma symptoms (*cough,*   *wheeze, shortness of breath, chest tightness*) more than twice  a week?  **Yes  No**   1. In the last month, have asthma symptoms woken you up at night or earlier than usual in the a.m. more than twice a week?   **Yes**  **No**   1. In the last month, have you used your rescue inhaler (*such as* *albuterol*) more than twice a week? **Yes No** 2. If you currently use a respirator, is it difficult to wear when you have asthma symptoms? **Yes  No** |  |  |
|  | c. Chronic Bronchitis |  |  |
|  | d. Emphysema |  |  |
|  | e. Pneumonia |  |  |
|  | f. Tuberculosis (TB) |  |  |
|  | g. Silicosis |  |  |
|  | h. Pneumothorax (collapsed lung) |  |  |
|  | i. Lung Cancer |  |  |
|  | j. Broken Rib(s) |  |  |
|  | k. Any chest injuries or surgeries? |  |  |
|  | l. Any other lung problem that you've been told about? |  |  |
|  |  |  |  |
| **4.** | Do you **currentl**y have any of the following symptoms of pulmonary or lung illness? | **YES** | **NO** |
|  | 1. Shortness of breath |  |  |
|  | **QUESTION** | **YES** | **NO** |
|  | b. Shortness of breath when walking fast on level ground or walking  up a slight hill or incline |  |  |
|  | c. Shortness of breath when walking with other people at an ordinary  pace on level ground |  |  |
|  | d.Have to stop for breath when walking at your own pace on level ground |  |  |
|  | e. Shortness of breath when washing or dressing yourself |  |  |
|  | f. Shortness of breath that interferes with your job |  |  |
|  | g. Coughing that produces phlegm (thick sputum) |  |  |
|  | h. Coughing that wakes you early in the morning |  |  |
|  | i. Coughing that occurs mostly when you are lying down |  |  |
|  | j. Coughing up blood in the last month |  |  |
|  | k. Wheezing |  |  |
|  | l. Wheezing that interferes with your job |  |  |
|  | m. Chest pain when you breathe deeply |  |  |
|  | n. Any other symptoms that you think may be related to lung  problems |  |  |
|  |  |  |  |
| **5.** | Have you **ever had** any of the following cardiovascular or heart problems? | **YES** | **NO** |
|  | a. Heart Attack |  |  |
|  | b. Stroke |  |  |
|  | c. Angina |  |  |
|  | d. Heart Failure |  |  |
|  | e. Swelling in your legs or feet (not caused by walking) |  |  |
|  | f. Heart Arrhythmia (heart beating irregularly) |  |  |
|  | g. High Blood Pressure |  |  |
|  | h. Any other heart problem that you've been told about |  |  |
|  |  |  |  |
| **6.** | Have you **ever had** any of the following cardiovascular or heart symptoms? | **YES** | **NO** |
|  | a. Frequent pain or tightness in your chest |  |  |
|  | b. Pain or tightness in your chest during physical activity |  |  |
|  | c. Pain or tightness in your chest that interferes with your job |  |  |
|  | d. In the past two years, have you noticed your heart skipping or  missing a beat |  |  |
|  | e. Heartburn or indigestion that is not related to eating |  |  |
|  | f. Any other symptoms that you think may be related to heart or  circulation problems |  |  |
|  |  |  |  |
| **7.** | Do you **currently** take medication for any of the following problems? | **YES** | **NO** |
|  | a. Breathing or lung problems |  |  |
|  | b. Heart trouble |  |  |
|  | c. Blood Pressure |  |  |
|  | d. Seizures |  |  |
|  |  |  |  |
|  | **QUESTIONS** | **YES** | **NO** |
| **8.** | If you've used a respirator, have you **ever had** any of the following problems while wearing a respirator?  **If you've never used a respirator, check here  and go to question 9.** |  |  |
|  | a. Eye Irritation |  |  |
|  | b. Skin Allergies or Rashes |  |  |
|  | c. Anxiety |  |  |
|  | d. General weakness or fatigue |  |  |
|  | e. Any other problem that interferes with your use of a respirator |  |  |
|  |  |  |  |
| **9.** | Would you like to talk to the healthcare professional who will review this questionnaire about your answers to the questionnaire? |  |  |
|  |  |  |  |
|  | ***Questions 10 - 15 must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees using other types of respirators, answering these questions is voluntary.*** |  |  |
| **10.** | Have you **ever** lost vision in either eye (temporarily or permanently)? |  |  |
|  |  |  |  |
| **11.** | Do you **currently** have any of the following vision problems? | **YES** | **NO** |
|  | a. Wear Contact Lenses |  |  |
|  | b. Wear Glasses |  |  |
|  | c. Color Blind |  |  |
|  | d. Any other eye or vision problem |  |  |
|  |  |  |  |
| **12.** | Have you **ever had** an injury to your ears, including a broken ear drum? |  |  |
|  |  |  |  |
| **13.** | Do you **currently** have any of the following hearing problems? | **YES** | **NO** |
|  | a. Difficulty Hearing |  |  |
|  | b. Wear a Hearing Aid |  |  |
|  | c. Any other Hearing or Ear Problem |  |  |
|  |  |  |  |
| **14.** | Have you **ever had** a back injury? |  |  |
|  |  |  |  |
| **15.** | Do you **currently** have any of the following musculoskeletal problems? | **YES** | **NO** |
|  | a. Weakness in any of your arms, hands, legs, or feet |  |  |
|  | b. Back pain |  |  |
|  | c. Difficulty fully moving your arms and legs |  |  |
|  | d. Pain or stiffness when you lean forward or backward at the waist |  |  |
|  | e. Difficulty fully moving your head up or down |  |  |
|  | f. Difficulty fully moving your head side to side |  |  |
|  | g. Difficulty bending at your knees |  |  |
|  | h. Difficulty squatting to the ground |  |  |
|  | i. Climbing a flight of stairs or a ladder carrying more than 25 lbs. |  |  |
|  | j. Any other muscle or skeletal problem that interferes with using a  respirator |  |  |

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| --- |
| **PART**  **PART B – OHS Use Only:**  🞎  Medically Cleared for Respirator Use Without Restrictions  Medically Cleared for Respirator Use **with following restrictions for**: N95 PAPR   1. No Respirator use if wheezing or shortness of breath evident 2. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pending PCP or Treating Specialist Recommendation Date of Request: \_\_\_ /\_\_\_ /\_\_\_\_\_\_\_    Pending OHS Physician Review  🞎  Not Medically Cleared to Wear a Respirator  **OHS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **OHS OHS CLINICIAN SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_ /\_\_\_ /\_\_\_\_\_\_\_\_ |